

Facility Name & ID Number Wynscape# 0041426 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>108</u>	Skilled (SNF)	<u>108</u>	<u>39,420</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>101</u>	Intermediate (ICF)	<u>101</u>	<u>36,865</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>209</u>	TOTALS	<u>209</u>	<u>76,285</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,691</u>	<u>3,816</u>	<u>16,638</u>	<u>31,145</u>	8
9	SNF/PED					9
10	ICF	<u>18,306</u>	<u>16,359</u>		<u>34,665</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,997</u>	<u>20,175</u>	<u>16,638</u>	<u>65,810</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.27%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 3/1/1996

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 3/1/1996 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 63 and days of care provided 14,065Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/2005 Fiscal Year: 6/30/2005

* All facilities other than governmental must report on the accrual basis.

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V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	399,420	28,374	115,816	543,610		543,610	(1,002)	542,608		1
2	Food Purchase		388,610		388,610		388,610		388,610		2
3	Housekeeping	236,375	11,134	156,041	403,550		403,550		403,550		3
4	Laundry	94,613	14,907		109,520		109,520		109,520		4
5	Heat and Other Utilities			257,791	257,791		257,791	3,042	260,833		5
6	Maintenance	77,130	27,285	222,275	326,690		326,690	109,944	436,634		6
7	Other (specify):*										7
8	TOTAL General Services	807,538	470,310	751,923	2,029,771		2,029,771	111,984	2,141,755		8
	B. Health Care and Programs										
9	Medical Director			31,187	31,187		31,187		31,187		9
10	Nursing and Medical Records	4,867,446	336,781	177,468	5,381,695		5,381,695		5,381,695		10
10a	Therapy	715,647	14,889	74,832	805,368		805,368		805,368		10a
11	Activities	157,789		5,165	162,954		162,954		162,954		11
12	Social Services	180,450		3,949	184,399		184,399		184,399		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,921,332	351,670	292,601	6,565,603		6,565,603		6,565,603		16
	C. General Administration										
17	Administrative	115,758		756,751	872,509		872,509	(276,581)	595,928		17
18	Directors Fees										18
19	Professional Services			17,750	17,750		17,750	66,194	83,944		19
20	Dues, Fees, Subscriptions & Promotions			11,572	11,572		11,572	2,075	13,647		20
21	Clerical & General Office Expenses	268,679	37,359	75,672	381,710		381,710	180,833	562,543		21
22	Employee Benefits & Payroll Taxes			1,783,126	1,783,126		1,783,126	125,321	1,908,447		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,035	17,035		17,035	3,726	20,761		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			713,101	713,101		713,101		713,101		26
27	Other (specify):*										27
28	TOTAL General Administration	384,437	37,359	3,375,007	3,796,803		3,796,803	101,568	3,898,371		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,113,307	859,339	4,419,531	12,392,177		12,392,177	213,552	12,605,729		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			474,906	474,906		474,906	37,295	512,201			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			208,588	208,588		208,588	(22,391)	186,197			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			33,686	33,686		33,686		33,686			35
36	Other (specify):*											36
37	TOTAL Ownership			717,180	717,180		717,180	14,904	732,084			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		526,900		526,900		526,900		526,900			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,428	114,428		114,428		114,428			42
43	Other (specify):*			224,207	224,207		224,207	(117,055)	107,152			43
44	TOTAL Special Cost Centers		526,900	338,635	865,535		865,535	(117,055)	748,480			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,113,307	1,386,239	5,475,346	13,974,892		13,974,892	111,401	14,086,293			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(28,024)	30		9
10	Interest and Other Investment Income	(22,391)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	43		24
25	Fund Raising, Advertising and Promotional	(93,055)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5a	(1,583)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (169,053)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	280,454		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 280,454		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 111,401		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (1,002)	1	1
2	Other Miscellaneous income	(425)	21	2
3	Finance charges	(156)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,583)		49

Summary A

June 30, 2005

Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS	
A. General Services												(to Sch V, col.7)	
Dietary	(1,002)	0	0	0	0	0	0	0	0	0	0	(1,002)	1
Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
Heat and Other Utilities	0	3,042	0	0	0	0	0	0	0	0	0	3,042	5
Maintenance	0	109,944	0	0	0	0	0	0	0	0	0	109,944	6
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
TOTAL General Services	(1,002)	112,986	0	0	0	0	0	0	0	0	0	111,984	8
B. Health Care and Programs													
Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
C. General Administration													
Administrative	0	(276,581)	0	0	0	0	0	0	0	0	0	(276,581)	17
Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
Professional Services	0	66,194	0	0	0	0	0	0	0	0	0	66,194	19
Fees, Subscriptions & Promotions	0	2,075	0	0	0	0	0	0	0	0	0	2,075	20
Clerical & General Office Expenses	(581)	181,414	0	0	0	0	0	0	0	0	0	180,833	21
Employee Benefits & Payroll Taxes	0	125,321	0	0	0	0	0	0	0	0	0	125,321	22
Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
Travel and Seminar	0	3,726	0	0	0	0	0	0	0	0	0	3,726	24
Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
TOTAL General Administration	(581)	102,149	0	0	0	0	0	0	0	0	0	101,568	28
TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,583)	215,135	0	0	0	0	0	0	0	0	0	213,552	29

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Summary B

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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(28,024)	65,319	0	0	0	0	0	0	0	0	0	37,295	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,391)	0	0	0	0	0	0	0	0	0	0	(22,391)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(50,415)	65,319	0	0	0	0	0	0	0	0	0	14,904	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(117,055)	0	0	0	0	0	0	0	0	0	0	(117,055)	43
44	TOTAL Special Cost Centers	(117,055)	0	0	0	0	0	0	0	0	0	0	(117,055)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(169,053)	280,454	0	0	0	0	0	0	0	0	0	111,401	45

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Central DuPage Health System (A Non-Profit Corp)	100			Central DuPage Hospital	Winfield, IL	Hospital
				CNS Home Care	Carol Stream, IL	Home Health
				Wyndmere Rtrmnt	Wheaton, IL	Ret. Community
				PAHCS II	Winfield, IL	Occup Med
				DuPage Health Svc	Winfield, IL	Lab
				CD Health	Winfield, IL	Pharmacy

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Central DuPage Health System	100.00%	\$ 3,042	\$ 3,042 1
2	V	6 Maintenance		Central DuPage Health System	100.00%	109,944	109,944 2
3	V	17 Administrative Services		Central DuPage Health System	100.00%	480,170	480,170 3
4	V	19 Legal and Professional Fees		Central DuPage Health System	100.00%	66,194	66,194 4
5	V	20 Licenses, Dues, Fees, etc		Central DuPage Health System	100.00%	2,075	2,075 5
6	V	21 Clerical and General Office		Central DuPage Health System	100.00%	181,414	181,414 6
7	V	22 Employee Benefits		Central DuPage Health System	100.00%	125,321	125,321 7
8	V	24 Travel and seminar		Central DuPage Health System	100.00%	3,726	3,726 8
9	V	30 Depreciation		Central DuPage Health System	100.00%	65,319	65,319 9
10	V						10
11	V						11
12	V	17 Management fees	756,751	Central DuPage Health System	100.00%		(756,751) 12
13	V						13
14	Total		\$ 756,751			\$ 1,037,205	\$ * 280,454 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	N/A - Nonprofit Corp.										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Central DuPage Health SystemStreet Address 27W353 Jewell RoadCity / State / Zip Code Winfield, IL 60190Phone Number (630) 933-5023Fax Number (630) 933-1800

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2	5	Utilities	Accumulated costs	397,119	8	87,898	13,743	3,042	2
3	6	Maintenance	Accumulated costs	397,119	8	3,176,936	13,743	109,944	3
4	17	Administrative services	Accumulated costs	397,119	8	13,874,829	13,743	480,170	4
5	19	Legal and professional fees	Accumulated costs	397,119	8	1,912,758	13,743	66,194	5
6	20	Dues, licenses & subscriptions	Accumulated costs	397,119	8	59,948	13,743	2,075	6
7	21	Clerical and general office	Accumulated costs	397,119	8	5,242,113	13,743	181,414	7
8	22	Employee benefits	Accumulated costs	397,119	8	3,621,263	13,743	125,321	8
9	24	Travel and seminar	Accumulated costs	397,119	8	107,671	13,743	3,726	9
10	30	Depreciation	Accumulated costs	397,119	8	1,887,472	13,743	65,319	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	29,970,888	\$	1,037,205	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Health Care Associates		X	Mortgage Note	\$60,195.00	1/1/2000	\$ 7,029,000	\$ 6,524,066	12/31/24	0.0925	\$ 208,588	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$60,195.00		\$ 7,029,000	\$ 6,524,066			\$ 208,588	9	
	B. Non-Facility Related*												
10	Interest Income Offset										(22,391)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (22,391)	14	
15	TOTALS (line 9+line14)						\$ 7,029,000	\$ 6,524,066			\$ 186,197	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Wynscape

0041426 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2000	8		
	2001	9		
	2002	10		
	2003	11		
	2004	12		
			FOR OHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wynscape COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0041426

CONTACT PERSON REGARDING THIS REPORT Jeff Hebreard

TELEPHONE (630) 933-5023 FAX #: (630) 933-1800

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	<u>N/A</u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

A. Square Feet: 58,390
 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Two

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>2000</u>	<u>\$ 1,800,000</u>	1
2					2
3	TOTALS			\$ 1,800,000	3

Facility Name & ID Number Wynscape

0041426

Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	209		2000		\$ 5,726,808	\$ 144,779	40	\$ 143,170	\$ (1,609)	\$ 787,436	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Elevator		7/1/1996		2,468		20	128	128	1,062	9
10	Facility project number 96071, See 12C for breakout		6/30/1997								10
11	General construction project number 96007		6/30/1997		154,315	1,851	40	3,858	2,007	30,942	11
12	Demolition		6/30/1997		14,620		40	366	366	3,111	12
13	Construction debris removal		6/30/1997		18,783		40	470	470	3,995	13
14	Excavation		6/30/1997		4,356		40	109	109	927	14
15	Concrete		6/30/1997		28,710		40	718	718	6,103	15
16	Unit masonry		6/30/1997		39,480		40	987	987	8,390	16
17	Rough carpentry		6/30/1997		1,488		40	37	37	315	17
18	Temporary protection cleanup		6/30/1997		10,767		40	269	269	2,287	18
19	Wood doors		6/30/1997		7,043		40	176	176	1,496	19
20	Spray on fire proofing		6/30/1997		11,800		40	295	295	2,508	20
21	Membrane roofing		6/30/1997		95,011		40	2,375	2,375	20,188	21
22	Metal door and frames		6/30/1997		14,369		40	359	359	3,052	22
23	Wood replacement doors		6/30/1997		4,381		40	110	110	935	23
24	Entrances and storefront		6/30/1997		28,398		40	710	710	6,035	24
25	Aluminum windows		6/30/1997		127,610		40	3,190	3,190	27,115	25
26	Hardware		6/30/1997		38,367		40	959	959	8,152	26
27	Interior glazing		6/30/1997		8,750		40	219	219	1,862	27
28	Drywall		6/30/1997		471,593		40	11,790	11,790	100,215	28
29	Ceramic tile		6/30/1997		34,909		40	873	873	7,421	29
30	Resilient flooring		6/30/1997		35,834		40	896	896	7,616	30
31	Floor prep		6/30/1997		1,809		40	45	45	383	31
32	Painting		6/30/1997		38,007		40	950	950	8,075	32
33	Toilet and bath accessories		6/30/1997		20,015		40	500	500	4,250	33
34	Kitchen and building allowance		6/30/1997		118,968		40	2,974	2,974	25,279	34
35	Window treatment allowance		6/30/1997		19,238		40	481	481	4,089	35
36	Storage / Moving		6/30/1997		1,748		40	44	44	374	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Wynscape

0041426

Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Final cleaning allowance	6/30/1997	\$ 11,225	\$	40	\$ 281	\$ 281	\$ 2,389		37
38	Field investigation	6/30/1997	900		40	23	23	196		38
39	Fire protection	6/30/1997	17,701		40	443	443	3,766		39
40	Plumbing	6/30/1997	155,685		40	3,892	3,892	33,082		40
41	HVAC	6/30/1997	24,900		40	623	623	5,296		41
42	Electrical	6/30/1997	322,774		40	8,069	8,069	68,587		42
43	Fire alarm system	6/30/1997	13,741		40	344	344	2,924		43
44	Premium time drvwll	6/30/1997	2,366		40	59	59	502		44
45	Reconstruction fee	6/30/1997	28,000		40	700	700	5,950		45
46	Fees to Schall Brothers	6/30/1997	72,379		40	1,809	1,809	15,377		46
47	Insurance	6/30/1997	17,277		40	432	432	3,672		47
48	Millwork	6/30/1997	61,115		40	1,528	1,528	12,989		48
49	Architect fees	7/31/1997	150,000		5			150,000		49
50	Architectural reimbursement	7/31/1997	10,952		5			10,952		50
51	Survey	7/31/1997	7,956		5			7,956		51
52	City permit fees	7/31/1997	4,886		5			4,886		52
53	Legal (contract only)	7/31/1997	6,927		5			6,927		53
54	Contingency fees	7/31/1997	36,385	2,241	10	3,639	1,398	25,052		54
55	Testing services	7/31/1997	10,864		5			10,864		55
56	Title insurance	7/31/1997	346		1			346		56
57	Landscaping	7/31/1997	45,000		5			45,000		57
58	Fence	7/31/1997	4,287		7	61	61	4,287		58
59	Balance of landscaping	10/23/1997	15,000	1,623	10	1,500	(123)	11,250		59
60	Seal stripe parking lot	10/28/1997	2,959		3			2,959		60
61	Elevator repairs	1/13/1998	11,000		20	565	565	4,170		61
62	Security system	2/3/1998	2,318		10	251	251	1,796		62
63	Elevator repairs	7/1/1998	1,500		3			1,500		63
64	Elevator repairs	11/18/1998	7,942		3			7,942		64
65	Gas water heater	11/10/1998	2,657		3			2,657		65
66	Smoke detectors	1/11/1999	2,225		3			2,225		66
67	Elevator repairs	1/13/1999	27,293		3			27,293		67
68	Elevator repairs	2/8/1999	6,349		3			6,349		68
69	Plumbing repairs	4/28/1999	700		3			700		69
70	TOTAL (lines 4 thru 69)		\$ 8,165,254	\$ 150,494		\$ 201,277	\$ 50,783	\$ 1,563,454		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,165,254	\$ 150,494		\$ 201,277	\$ 50,783	\$ 1,563,454	1
2	Rear door repairs	5/15/1966	2,799		3			2,799	2
3	Prior year improvement to facility project number 96071:								3
4	General contractor cost	6/30/1997	145,836	17,349	40	3,646	(13,703)	34,637	4
5	Construction insurance	6/30/1997	10,702	1,273	40	268	(1,005)	2,546	5
6	Fire alarm system	6/30/1997	8,717	1,037	40	218	(819)	2,071	6
7	Electrical work	6/30/1997	69,239	8,236	40	1,731	(6,505)	16,445	7
8	HVAC improvement work	6/30/1997	394,855	46,969	40	9,871	(37,098)	93,775	8
9	Plumbing improvement	6/30/1997	86,233	10,258	40	2,156	(8,102)	20,482	9
10	Fire protection work	6/30/1997	2,096	249	40	52	(197)	494	10
11	Elevators work	6/30/1997	1,595	190	40	40	(150)	380	11
12	Storage and moving cost	6/30/1997	19,125	2,275	40	478	(1,797)	4,541	12
13	Window treatment improvements	6/30/1997	14,142	1,682	40	354	(1,328)	3,363	13
14	Painting work	6/30/1997	212,678	25,299	40	5,317	(19,982)	50,512	14
15	Resilient flooring	6/30/1997	161,133	19,167	40	4,028	(15,139)	38,266	15
16	Acoustical treatment	6/30/1997	102,956	12,247	40	2,574	(9,673)	24,453	16
17	Ceramic tile	6/30/1997	8,396	999	40	210	(789)	1,995	17
18	Drywall	6/30/1997	11,049	1,314	40	276	(1,038)	2,622	18
19	Hardware	6/30/1997	54,460	6,478	40	1,362	(5,116)	12,939	19
20	Aluminum windows	6/30/1997	2,616	311	40	65	(246)	618	20
21	Roofing	6/30/1997	13,942	1,658	40	349	(1,309)	3,316	21
22	Wood door	6/30/1997	1,802	214	40	45	(169)	428	22
23	Unit masonry	6/30/1997	7,316	870	40	183	(687)	1,739	23
24	Cast in place concrete	6/30/1997	13,275	1,579	40	332	(1,247)	3,154	24
25	Unlocated Difference on Depr on 1997 assets			(46,742)			46,742		25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,510,216	\$ 263,406		\$ 234,832	\$ (28,574)	\$ 1,885,029	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wynscape

0041426

Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,510,216	\$ 263,406		\$ 234,832	\$ (28,574)	\$ 1,885,029	1
2	Disposer and wall heating and cooling units	7/1/1998	8,549		3			8,549	2
3	Roof covering and gutters	1/13/1998	4,345		3			4,345	3
4	Elevator repairs	6/30/1999	1,600		3			1,600	4
5	Elevator repairs	6/30/1999	15,078		3			15,078	5
6	Assets After 6/30/99:								6
7	Toilet replacement	7/1/1999	12,397		3			12,397	7
8	Toilet replacement	8/1/1999	1,194		3			1,194	8
9	Plumbing and electrical work	7/1/1999	4,100		3			4,100	9
10	Elevator repairs and electric	7/1/1999	31,402		3			31,402	10
11	Sidewalk repair	7/1/1999	1,892		3			1,892	11
12	Door holders	12/31/1999	4,784		3			4,784	12
13	Electrical panel repair	12/31/1999	4,900		3			4,900	13
14	Nurse call system	2/29/2000	9,083		3			9,083	14
15	Nurse call system	2/29/2000	54,480		3			54,480	15
16	Detail of building improvements 06/30/2000								16
17	General contractor cost	6/30/2000	22,010		40	550	550	3,025	17
18	Demolition cost	6/30/2000	622	16	40	16		84	18
19	Concrete cost	6/30/2000	2,119	53	40	53		295	19
20	Masonry cost	6/30/2000	2,223	55	40	55		306	20
21	Carpentry and fireproofing cost	6/30/2000	2,140	53	40	53		295	21
22	Roofing cost	6/30/2000	4,093	103	40	103		563	22
23	Entrance improvements	6/30/2000	1,583	39	40	39		218	23
24	Windows cost	6/30/2000	6,191	155	40	155		849	24
25	Hardware cost	6/30/2000	3,761	94	40	94		517	25
26	Drywall cost	6/30/2000	18,998	475	40	475		2,616	26
27	Ceramic tile and flooring	6/30/2000	12,892	323	40	323		1,773	27
28	Painting and decorating	6/30/2000	10,437	261	40	261		1,432	28
29	Kitchen and millwork improvements	6/30/2000	6,860	171	40	171		944	29
30	Plumbing and electrical work	6/30/2000	24,433	611	40	611		3,357	30
31	HVAC work	6/30/2000	16,892	423	40	423		2,323	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,799,274	\$ 266,238		\$ 238,214	\$ (28,024)	\$ 2,057,430	34

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12D

Facility Name & ID Number Wyncscape

0041426

Report Period Beginning:

July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,799,274	\$ 266,238		\$ 238,214	\$ (28,024)	\$ 2,057,430	1
2	Carpet	2002	2,035	293	7	293		1,022	2
3	Electrical	2002	5,722	284	20	284		997	3
4	Emergency generator system and facility rewiring	2002	919,934	45,996	20	45,996		160,987	4
5	First floor renovation	2002	367,252	18,363	20	18,363		64,270	5
6	Hot water heaters	2002	67,944	3,397	20	3,397		11,890	6
7	Nurse call system	2002	31,433	1,571	20	1,571		5,499	7
8	Mechanical (oxvgen distribution system)	2002	38,241	1,912	20	1,912		6,692	8
9	Plumbing	2002	2,961	148	20	148		518	9
10	HVAC	2002	47,353	2,368	20	2,368		8,288	10
11	Painting and decorating	2002	21,585	1,079	20	1,079		3,777	11
12	Roof replacement	2002	99,498	4,921	20	4,921		17,250	12
13	Service elevator modernization	2002	44,119	2,206	20	2,206		7,721	13
14	Soft costs	2002	65,031	3,252	20	3,252		11,382	14
15	Mechanical	2002	54,389	2,720	20	2,720		9,519	15
16	Monument sign	2002	16,917	1,692	10	1,692		5,922	16
17	Site drainage	2002	59,341	2,967	20	2,967		10,385	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,643,029	\$ 359,407		\$ 331,383	\$ (28,024)	\$ 2,383,549	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,643,029	\$ 359,407		\$ 331,383	\$ (28,024)	\$ 2,383,549	1
2	Security cameras	6/30/2003	14,922	746	20	746		1,865	2
3	Electrical updates	6/30/2003	626	31	20	31		78	3
4	Electrical updates	6/30/2003	19	1	20	1		2	4
5	Electrical updates	6/30/2003	861	43	20	43		108	5
6	Electrical updates	6/30/2003	45	2	20	2		5	6
7	CDH PO# 174903 - project # 21165	6/30/2003	8,486	424	20	424		1,060	7
8	Miner & East	6/30/2003	14,740	737	20	737		1,843	8
9	Extractor	6/30/2003	556	28	20	28		70	9
10	Engineering	6/30/2003	4,470	224	20	224		560	10
11	Office renovation	6/30/2003	448	22	20	22		55	11
12	Labor	6/30/2003	56	3	20	3		7	12
13	Labor	6/30/2003	1,344	67	20	67		168	13
14	Emergency shower repair	6/30/2003	4,780	239	20	239		598	14
15	Electrical updates	6/30/2003	2,340	117	20	117		293	15
16	Cindy Smith	6/30/2003	663	33	20	33		83	16
17	Miner & East	6/30/2003	154,919	7,746	20	7,746		19,365	17
18	Miner & East	6/30/2003	8,563	428	20	428		1,070	18
19	Ice cream parlor	6/30/2003	679	34	20	34		85	19
20	Office renovation	6/30/2003	6,600	330	20	330		825	20
21	Office renovation	6/30/2003	448	22	20	22		55	21
22	Code regulation for storage	6/30/2003	15,195	760	20	760		1,900	22
23	Plumbing	6/30/2003	11,583	579	20	579		1,448	23
24	Dust control assembly	6/30/2003	1,220	61	20	61		244	24
25	Shower room repair	6/30/2003	1,877	94	20	94		376	25
26	Smoke / fire dampers	6/30/2003	1,954	98	20	98		391	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,900,423	\$ 372,276		\$ 344,252	\$ (28,024)	\$ 2,416,103	34

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 11,900,423	\$ 372,276		\$ 344,252	\$ (28,024)	\$ 2,416,103	1
2									2
3	Labor	6/30/2004	858	43	20	43		64	3
4	Engineering	6/30/2004	4,470	223	20	223		335	4
5	Skilled Nrsng Rev	6/30/2004	663	33	20	33		49	5
6	Skilled Nrsng Rev	6/30/2004	846	42	20	42		63	6
7	Supply desk	6/30/2004	556	56	10	56		84	7
8	C.S. Artwork	6/30/2004	122	12	10	12		18	8
9	CS Artwork	6/30/2004	33	3	10	3		4	9
10	Concrete Sealcoat	6/30/2004	1,796	180	10	180		270	10
11	Anderson Mikos Prof Svcs	6/30/2004	3,735	187	20	187		280	11
12	Troyer Group Svcs	6/30/2004	8,419	421	20	421		631	12
13	Anderson Mikos Prof Svcs	6/30/2004	2,343	117	20	117		176	13
14	Anderson Mikos Prof Svcs & Architect	6/30/2004	6,175	309	20	309		463	14
15	IDPA work	6/30/2004	3,180	159	20	159		238	15
16	Troyer Group Redecorating	6/30/2004	10,157	508	20	508		762	16
17	Hot Water Heater	6/30/2004	12,985	649	20	649		974	17
18	Troyer Group Redecorating - Phase I	6/30/2004	11,633	582	20	582		873	18
19	Troyer Group Redecorating - Phase I	6/30/2004	6,810	340	20	340		510	19
20	Troyer Group inv	6/30/2004	8,610	430	20	430		645	20
21	2005 Additions:								21
22	Troyer Group Remodeling	6/30/2005	287	7	20	7		7	22
23	Coppolino Design - Phase 1	6/30/2005	203	5	20	5		5	23
24	The Troyer Remodeling Phase 1	6/30/2005	9,066	226	20	226		226	24
25	Phase 1 Remodeling	6/30/2005	151,459	3,786	20	3,786		3,786	25
26	Remodeling Phase 2	6/30/2005	100,950	2,524	20	2,524		2,524	26
27	Remodeling First Floor	6/30/2005	146,555	3,664	20	3,664		3,664	27
28	Security System	6/30/2005	17,260	863	10	863		863	28
29	Remodeling First Floor	6/30/2005	390	10	20	10		10	29
30	Prints and Installs	6/30/2005	3,065	153	10	153		153	30
31	Summary Billing Furniture	6/30/2005	38,223	956	20	956		956	31
32									32
33	Depreciation Allocated from Central DuPage Health System					65,319	65,319		33
34	TOTAL (lines 1 thru 33)		\$ 12,451,272	\$ 388,764		\$ 426,059	\$ 37,295	\$ 2,434,736	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 781,097	\$ 78,136	\$ 78,136		3-10 yrs	\$ 580,399	71
72	Current Year Purchases	112,083	8,006	8,006		5-7 yrs	8,006	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 893,180	\$ 86,142	\$ 86,142			\$ 588,405	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transport	1997 Ford Van	1998	\$ 45,524					\$ 45,524	76
77										77
78										78
79										79
80	TOTALS			\$ 45,524					\$ 45,524	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 15,189,976	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 474,906	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 512,201	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 37,295	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,068,665	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$		91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A

N/A

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 33,686

Description: Misc. - See Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>	<u>N/A</u>	\$ <u>N/A</u>	\$ <u>N/A</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2006 \$ _____

13. /2007 \$ _____

14. /2008 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA _____
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8						
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	Ln10a, Col 1	5205	hrs	\$	129,706		\$	5,205	\$	129,706	1			
2	Licensed Speech and Language Development Therapist	Ln10a, Col 1	2495	hrs		85,445			2,495		85,445	2			
3	Licensed Recreational Therapist			hrs								3			
4	Licensed Physical Therapist	Ln10a,Col 1&2	9745	hrs		260,749		14,889	9,745		275,638	4			
5	Physician Care			visits								5			
6	Dental Care			visits								6			
7	Work Related Program			hrs								7			
8	Habilitation			hrs								8			
9	Pharmacy	Ln 39, Col 2		# of prescrpts				526,900			526,900	9			
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10			
10	Academic Education			hrs								11			
11	Exceptional Care Program											12			
12															
13	Other (specify): IV Therapy	Ln 10a, Col 3					74,832				74,832	13			
14	TOTAL				\$	475,900		\$	74,832	\$	541,789	17,445	\$	1,092,521	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on
 Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed
 on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 332,594	\$ 332,594	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 40,600)	1,588,554	1,588,554	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	82,756	82,756	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Misc Receivables</u>	161,646	161,646	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,165,550	\$ 2,165,550	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,800,000	1,800,000	13
14	Buildings, at Historical Cost	13,737,982	13,737,982	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	938,704	938,704	16
17	Accumulated Depreciation (book methods)	(3,609,286)	(3,609,286)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Board Restr Funds</u>	661	661	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,868,061	\$ 12,868,061	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,033,611	\$ 15,033,611	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,352,394	\$ 1,352,394	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	124,992	124,992	29
30	Accrued Salaries Payable	257,234	257,234	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Insurance and Other Exp</u>	721,986	721,986	36
37	<u>Refundable Deposits</u>	32,846	32,846	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,489,452	\$ 2,489,452	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,399,074	6,399,074	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,399,074	\$ 6,399,074	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,888,526	\$ 8,888,526	46
47	TOTAL EQUITY (page 18, line 24)	\$ 6,145,085	\$ 6,145,085	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,033,611	\$ 15,033,611	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,751,691	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,751,691	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(598,206)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Unrlzd Loss in Mkt Value of Invstmts	(8,404)	15
16	Other (describe) Misc rounding variance	4	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (606,606)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,145,085	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Wynscape

0041426

Report Period Beginning: July 1, 2004

Ending: June 30, 2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 18,789,392	1
2	Discounts and Allowances for all Levels	(5,437,469)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,351,923	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,372	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,372	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	22,391	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,391	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,376,686	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,029,771	31
32	Health Care	6,565,603	32
33	General Administration	3,796,803	33
B. Capital Expense			
34	Ownership	717,180	34
C. Ancillary Expense			
35	Special Cost Centers	751,107	35
36	Provider Participation Fee	114,428	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,974,892	40
41	Income before Income Taxes (line 30 minus line 40)**	(598,206)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (598,206)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Wynscape

0041426

Report Period Beginning: July 1, 2004

Ending: June 30, 2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,621	2,668	\$ 86,344	\$ 32.36	1
2	Assistant Director of Nursing	3,575	4,890	138,427	28.31	2
3	Registered Nurses	65,742	95,899	2,286,644	23.84	3
4	Licensed Practical Nurses	9,989	15,479	263,184	17.00	4
5	CNAs & Orderlies	130,293	204,341	2,029,954	9.93	5
6	CNA Trainees					6
7	Licensed Therapist	13,828	17,446	475,900	27.28	7
8	Rehab/Therapy Aides	12,320	17,402	239,747	13.78	8
9	Activity Director	1,571	2,507	46,180	18.42	9
10	Activity Assistants	10,042	14,761	111,609	7.56	10
11	Social Service Workers	10,526	13,540	180,450	13.33	11
12	Dietician	1,990	2,495	44,779	17.95	12
13	Food Service Supervisor	4,150	6,418	70,741	11.02	13
14	Head Cook	5,812	9,744	80,090	8.22	14
15	Cook Helpers/Assistants	20,493	31,964	203,810	6.38	15
16	Dishwashers					16
17	Maintenance Workers	4,620	7,567	77,130	10.19	17
18	Housekeepers	23,293	37,390	236,375	6.32	18
19	Laundry	7,888	12,455	94,613	7.60	19
20	Administrator	2,087	2,827	115,758	40.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,873	21,739	268,679	12.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	328	449	4,995	11.12	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,907	5,067	57,898	11.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	349,948	527,048	\$ 7,113,307 *	\$ 13.50	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	38	\$ 1,721	Ln 1, C.3	35
36	Medical Director	156	31,187	Ln 9, C.3	36
37	Medical Records Consultant	37	2,389	Ln 10, C.3	37
38	Nurse Consultant	N/A	1,980	Ln 10, C.3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	81	4,000	Ln 11, C.3	44
45	Social Service Consultant	83	3,948	Ln 12, C.3	45
46	Other(specify)				46
47	Dietary Temp Personnel	527	7,156	Ln 1, C.3	47
48					48
49	TOTAL (lines 35 - 48)	922	\$ 52,381		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,285	\$ 73,492	Ln 10, C.3	50
51	Licensed Practical Nurses	799	32,467	Ln 10, C.3	51
52	Certified Nurse Assistants/Aides	2,968	67,140	Ln 10, C.3	52
53	TOTAL (lines 50 - 52)	5,052	\$ 173,099		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description		Amount	
Renee Cisewski	Administrator	0	\$ 84,541	Workers' Compensation Insurance		\$ 87,294	IDPH License Fee		\$	
Judith A. Perry	Administrator	0	31,217	Unemployment Compensation Insurance		76,342	Advertising: Employee Recruitment			
				FICA Taxes		498,987	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance		766,987	Life Services Network Dues		8,146	
				Employee Meals			Misc Other Dues		285	
				Illinois Municipal Retirement Fund (IMRF)*			DuPage County Health		770	
				Disability Insurance		25,180	Misc Other Licenses		1,369	
				Life Ins		8,159	Misc Subscriptions		1,002	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 115,758	Pension & MSP		318,372	Allocation from Home Office		2,075	
B. Administrative - Other				Employee recognition		600	Less: Public Relations Expense		(
				Uniforms		1,205	Non-allowable advertising		(
				Home Office Allocation		125,321	Yellow page advertising		(
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,908,447	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 13,647	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services				Description		Line #	Description		Amount	
Vendor/Payee	Type		Amount							
Sachnoff & Weaver Ltd	Legal Fees		\$ 230	N/A			Out-of-State Travel		\$	
KPMG LLP	Audit Fees		17,520							
							In-State Travel			
							Various per Schedule		5,814	
							Seminar Expense			
							Various per Schedule		11,221	
							Home Office Allocation		3,726	
							Entertainment Expense		(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 17,750	TOTAL		\$	(agree to Sch. V, line 24, col. 8)			
							TOTAL		\$ 20,761	

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number Wynscape

STATE OF ILLINOIS

0041426

Report Period Beginning: July 1, 2004

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Ending: June 30, 2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Svcs Network of IL, \$ 8146
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 70,121 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 114,428
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.